Rule and Regulation 43

UNFAIR CLAIMS SETTLEMENT PRACTICES

Sections

Section 1. Purpose

The purpose of this rule is to define certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claims settlement practices. Ark. Code Ann. §§ 23-66-201(1987), et seq., and 23-76-103 (1987), 23-76-119 (1987) and 23-94-204 (Supp. 1987) prohibit insurers, health maintenance organizations and risk retention groups doing business in the State of Arkansas from engaging in unfair claims settlement practices; and provide that, if any insurer or health maintenance organization or risk retention group performs any of the acts or practices proscribed by those sections with such frequency as to indicate a general business practice, then those acts shall constitute an unfair or deceptive act or practice in the business of insurance.

Section 2. Authority.

This rule is issued pursuant to the authority vested in the Commissioner by Ark. Code Ann. §§ 23-61-108(1987), 23-66-207(1987), 23-76-125(1987), 23-94-107(Supp. 1987), 25-15-202(1987), et seq., and other applicable provisions of Arkansas law.

Section 3. Applicability and scope.

This rule applies to all persons, to all insurance policies and insurance contracts and to all contracts, certificates, subscriber agreements, or other evidences of coverage issued by insurers, health maintenance organizations and risk retention groups, as applicable, except policies of

Workers' Compensation and Employer's Liability. This rule is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of Ark. Code Ann. §§ 23-66-201(1987), et seq., and 23-76-103(1987), and 23-76-119(1987).

Section 4. Effective date.

The effective date of this rule is January 1, 1989.

Section 5. Definitions.

The definitions of "person," "evidence of coverage," and of "insurance policy or insurance contract" contained in the Trade Practices Act, Ark. Code Ann. § 23-66-203(1987), and in Ark. Code Ann. § 23-76-102 (1987), shall apply to this regulation and, in addition, where used in this regulation:

(a) "Agent" or "Representative" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer, health maintenance organization, or risk retention group with respect to a claim;

(b) "Automobile insurance" includes, but is not limited to, insurance as defined under Ark. Code Ann. § 23-89-301(1987);

(c) "Claimant" means an enrollee, a first party claimant, and/or a third party claimant, and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(d) "Complaint" means a written communication primarily expressing a grievance;

(e) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment or services under an insurance policy or contract, or health care plan arising out of the occurrence of the contingency, loss, injury, or illness covered by such policy, or contract, or plan;

(f) "Insurance Department Complaint" means a written communication regarding a complaint transmitted by the Arkansas Insurance Department;

(g) "Insurance" means any person, health maintenance organization, or risk retention group licensed or registered to issue or who issues any insurance policy or contract in this State, including any services or claims administrators as referenced in Ark. Code Ann. §§23-63-105, 23-79-127, and 23-92-201;

(h) "Investigation" means all activities of an insurer directly or indirectly related to determination of liabilities or obligations under coverages afforded by a policy, contract, or health care plan;

(i) "Notification of claim" means any notification, whether in writing or by other means acceptable under the terms of an insurance policy, contract, or health care plan to an insurer or its agent by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(j) "Risk retention group" means a group as defined under Ark. Code Ann. § 23-94-102 (10) (Supp. 1987);

(k) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract; and

(l) "Workers' Compensation" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

Section 6. File and record documentation.

The claim files of insurers shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

Section 7. Failure to Acknowledge Pertinent Communications.

(a) Every insurer, upon receiving notification of a claim shall, within fifteen (15) working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than in writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer. Pursuant to Ark. Code Ann. § 23-79-126(1987), insurers shall furnish forms for proof of loss within twenty (20) calendar days after a loss has been reported, or thereafter waive proof of loss requirements. Insurers shall not require a claimant to calculate depreciated value of personal property on forms for proof of loss.

(b) Every insurer upon receipt of any inquiry from the Arkansas Insurance Department respecting a claim shall within fifteen (15) working days of such inquiry furnish the Department with a reasonably adequate response to the inquiry.

(c) An appropriate reply shall be made within fifteen (15) working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance to claimants so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

Section 8. Standards for Prompt Investigation of Claims.

Every insurer shall complete investigation of a claim within forty-five (45) calendar days after notification of claim, unless such investigation cannot reasonably be completed within such time. If an investigation cannot be completed within the forty-five (45) day time period, insurers shall notify claimants that additional time is required and include with such notification the reasons therefore.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Insurers

The provisions of this section shall not apply to surety and fidelity insurance, or to mortgage guaranty, or other forms of insurance offering protection against investment risks.

(a)(1) Within fifteen (15) working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant in writing within fifteen (15) working days after receipt of the proofs of loss, stating the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five (45) calendar days from the date of the initial notification and not more than every forty-five (45) calendar days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(b) Where there is a reasonable basis supported by specific information available for review by the Arkansas Insurance Department that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subsection (a)(1). The claimant shall be advised of the acceptance or denial of the claim within a reasonable time following a full investigation after receipt by the insurer of a properly executed proof of loss. The insurer shall comply with the provisions of the Arson Reporting-Immunity Statute, Ark. Code Ann. §§ 12-13-301(1987) - 12-13-305(1987).

(c) Insurers shall not refuse to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.

(d) Insurers shall not continue or prolong negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty (30)

working days and to third party claimants sixty (60) calendar days before the date on which such time limit may expire.

(e) No insurer shall make statements which indicate the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the applicable provision of a statute of limitations, as provided in subsection (d) of this section.

(f) Insurers shall mail or deliver claim checks or drafts to claimants within ten (10) working days after the claims are processed, all claim investigations are completed and said claim files are closed and ready for payment.

(g) No insurer or its agents and representatives shall fail to disclose fully to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or contract under which a claim is presented.

(h) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(i) No insurer shall deny a claim for a claimant's failure to exhibit the damaged property without proof of demand and of an unfounded refusal by the claimant to do so.

(j) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time and which seek to relieve the company of its obligations if such a time limit is not complied with, unless the failure to comply with such time limit prejudices the insurer's rights.

(k) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(l) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contains language which releases the insurer or its insured from total liability.

(m) No insurer shall delay payment of any claim under specific coverages under a contract in an attempt to settle all or a portion of the claims under other coverages provided by the policy.

Section 10 Standards for Prompt, Fair and Equitable Settlements Applicable to Private Passenger Automobile Insurance

(a) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one (1) of the following methods must apply:

(1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured. All applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile must be paid at no cost to the insured other than the policy deductible. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile, including all applicable taxes, license fees and other fees actually incurred incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:

(A) The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area; or

(B) Use of one (1) of two (2) or more quotations obtained by the insurer from two (2) or more qualified dealers or appraisal services located within the local market area when a comparable automobile is not available in the local market area.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections (a)(1) and (2) of this section, the deviation must be supported by documentation giving particulars of the automobile's condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.

(b) Where liability and damages are reasonably clear, insurers shall not recommend or require that third party claimants make a claim under their own policies solely to avoid paying claims under such insurer's policy or contract.

(c) Insurers shall not require a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate, or to have the automobile repaired at a specific repair shop. Insurers shall not require a claimant to have the automobile repaired at a specific repair shop as a condition of recovery.

(d) Insurers shall include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

(e) When the insurer elects to repair, and, with the insured's written consent, a specific repair shop is selected, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at the estimate cost with no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(f) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one (1) or more conveniently located repair shops.

(g) When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

Section 11. Standards for Prompt, Fair and Equitable Settlements Applicable to Disability Insurance.

Insurers and health maintenance organizations issuing individual, group, and blanket disability policies or contracts shall adhere to the provisions of Ark. Code Ann. §§23-85-112 (1987), 23-86-102(1987), and 23-86-108(Supp. 1987), as to furnishing written proofs of loss to insureds and contractholders, and as to time for payment of claims, as applicable. With respect to such claim settlements, insurers and health maintenance organizations shall not:

a) Delay the processing of any claim in order to handle another claim in a more timely manner as part of a discount payment plan; or

b) Delay claims processing with excessive, repetitious and duplicative requests for information to claimants and their health care providers; or

c) Delay claims processing by failing to request all information necessary to evaluate claims in a timely manner.

Section 12. Minimum Standards for Pre-Certification or Pre-AuthorizationR reviews as to Disability Coverage

The purpose of this section is to define certain minimum standards for insurers utilizing pre-certification or pre-authorization reviews to ensure that such cost-containment procedures of disability insurers and health care plans are reasonable and do not unduly delay, or interfere with or impede the authorized practice of medicine and delivery of reasonable medical care. For purposes of this rule, acts of the claims administrator in performing pre-certification reviews shall be deemed to be acts of the insurer.

From and after one hundred and eighty (180) days from the effective date of this rule, insurers utilizing such reviews shall establish reasonable procedures to:

(a) Ensure that pre-certification reviews are completed in a prompt and timely manner;
(b) Avoid excessive, repetitious and duplicative requests for information to claimants and their health care providers;
(c) Provide for reconsideration or medical reviews following disapproval or denial of pre-certification requests of insureds and claimants; and
(d) Provide for prompt peer medical review following disapproval or denial of pre-certification requests of insureds or claimants as to medically-necessary and/or life-threatening major surgical procedures.

Section 713. Severability

Any section or provision of this rule held by a court to be invalid or unconstitutional will not affect the validity of any other section or provision of this rule.

(signed by the Commissioner)
ROBERT M. EUBANKS, III
INSURANCE COMMISSIONER

November 8, 1988
DATE